STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner **File No. 88426-001**

v

Blue Cross and Blue Shield of Michigan
Respondent
_____/

Issued and entered
This 12th day of May 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On March 11, 2008, XXXXX, on behalf of his minor daughter XXXXX (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. The Commissioner reviewed the request and determined it was incomplete. After additional information was provided it was accepted for external review on April 2, 2008.

The Commissioner notified Blue Cross and Blue Shield of Michigan (BCBSM) of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on April 7, 2008.

The issue in this external review can be decided by a contractual analysis. The contract here is the BCBSM Flexible Blue Group Benefits Certificate (the certificate). The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II
FACTUAL BACKGROUND

From March 12 through April 15, 2007, and from May 8 through July 5, 2007, the Petitioner received residential treatment for anorexia nervosa at the XXXXXX.[1] The total amount charged for this care was $53,261.00. BCBSM denied coverage for this treatment.

The Petitioner appealed BCBSM's denial of coverage. BCBSM held a managerial-level conference on January 24, 2008, and issued a final adverse determination dated January 31, 2007.

III
ISSUE

Is BCBSM required to pay for the care provided the Petitioner at the XXXXX in 2007?

IV
ANALYSIS

Petitioner's Argument

The Petitioner's coverage with BCBSM was effective on March 1, 2007. According to the Petitioner's father, less than two months before that date the insurance agent assured him that residential mental health benefits were included in his coverage. On March 5, 2007, XXXXX of BCBSM also indicated to the Petitioner's family and to XXXXX that they had 60 days per calendar year of residential benefits. Based on these assurances and language in the "Benefits at-a-Glance" document, the Petitioner says that she believed she was covered for 60 days of residential mental health care and proceeded with her admission to XXXXX for treatment of her anorexia nervosa.

Half way through the Petitioner's treatment at XXXXX, the hospital was informed by BCBSM that there was no coverage for long-term non-acute facilities. The Petitioner says this information contradicted BCBSM's original coverage quotes.

The Petitioner says that it is "shameful" that residential treatment for anorexia nervosa is not covered. Since BCBSM has denied coverage, the Petitioner's family is now responsible for paying for her treatment. Her family expected that a large, respected company like BCBSM would go above what Michigan law requires.

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1 From April 16 to May 7, 2007, the Petitioner received inpatient care at XXXXX. Apparently that care was covered and is not an issue in this external review.

The Petitioner argues that she had a very serious condition -- her weight had dropped to 65 pounds – and her care at XXXXX was medically necessary. She believes that BCBSM should be required to pay for it.

BCBSM's Argument

In Section 3, *Coverage for Hospital, Facility and Alternatives to Hospital Care*, the certificate says that BCBSM pays benefits provided in or by a participating hospital or facility, including inpatient hospital services, outpatient hospital and facility services, freestanding ambulatory surgery facility services, freestanding outpatient physical therapy facility service, home health care services, home infusion therapy, hospice care services, and skilled nursing facility services.

The Petitioner's services were rendered at the XXXXX, which BCBSM says does not qualify as a hospital, facility, or alternative to hospital care as described under the certificate.

BCBSM realizes that this treatment program was recommended for the Petitioner. However, there simply are no provisions in the contract to cover residential treatment programs such as this. Therefore, BCBSM says the Petitioner's services were denied appropriately.

Commissioner's Review

The certificate describes how benefits are paid. It explains that BCBSM pays for hospital, facility, and certain alternatives to hospital care. The Petitioner's care at the XXXXX does not meet the definition of a hospital or any of the other covered facilities (or alternatives to facilities) listed or described in the certificate. Residential care such as the Petitioner received is not a covered benefit. (The certificate covers inpatient mental health care but residential care is not the same as inpatient care.) No information was provided to show that the care the Petitioner received at the XXXXX was anything other than residential in nature.

The Petitioner argues that she and XXXXX were misled to believe her residential mental health care would be a covered benefit. BCBSM indicated that it does not believe it misled the Petitioner. It is unfortunate if the Petitioner relied on any representations from the insurance agent or BCBSM about coverage that were not correct. However, under the Patient's Right to Independent Review Act (PRIRA), the Commissioner's role is limited to determining whether a

health plan has correctly administered benefits under the terms of the applicable insurance contract and state law. The Commissioner cannot resolve factual disputes such as the one described here because the PRIRA lacks the hearing process necessary to make findings of fact based on evidence such as oral statement. Moreover, PRIRA does not give the Commissioner the authority (which the circuit courts possess) to order relief based on doctrines such as estoppel or waiver.

In conclusion, the Commissioner finds that BCBSM correctly applied the provisions of the certificate for the Petitioner's care at XXXXX.

V
ORDER

BCBSM's final adverse determination of January 31, 2007 is upheld. BCBSM is not required to pay for the Petitioner's residential care at the XXXXX.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the Circuit Court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

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Ken Ross
Commissioner